STATE OF MICHIGAN

COURT OF APPEALS

ELIZABETH MORDEN, Personal Representative of the Estate of CHRISTOPHER MORDEN,

Plaintiff-Appellant,

v

ANNE MARIE BAASE, JIM TALBOT, and TONY KARLIN,

Defendants,

and

GRAND TRAVERSE COUNTY, GRAND TRAVERSE COUNTY JAIL, MARILYN CONLON, M.D., WELL-SPRING PSYCHIATRY, P.C., MARGARET SCHOFIELD, R.N., ELAIN LOZEN, R.N., SANDI MINOR, R.N., DAVID WILCOX, D.O., and GRAND TRAVERSE COUNTY SHERIFF,

Defendants-Appellees.

UNPUBLISHED
August 6, 2009

No. 285024
Grand Traverse Circuit Court
LC No. 04-024311-NM

Before: O'Connell, P.J., and Bandstra and Donofrio, JJ.

PER CURIAM.

Plaintiff appeals by leave granted the trial court's orders summarily disposing of her state law medical malpractice claims pursuant to MCR 2.116(C)(7), and of her federal claims against defendants David Wilcox, D.O., and Margaret Schofield, R.N., pursuant to MCR 2.116(C)(8) and (10). We affirm in part, reverse in part and remand for further proceedings consistent with this opinion.

This case arises out of the death of Christopher R. Morden (the decedent) while housed at the Grand Traverse County Jail. As this Court explained in its prior published opinion in this case, *Morden v Grand Traverse Co*, 275 Mich App 325, 327-333; 738 NW2d 278 (2007)[1]:

> Plaintiff Elizabeth Morden, as personal representative of the estate of her son, the decedent, has sued defendants Marilyn E. Conlon, M.D., and David J. Wilcox, D.O., among others, asserting state law malpractice claims and federal constitutional claims under 42 USC 1983. . . .
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> The essential facts are largely undisputed. After being arrested on February 4, 2002, the decedent claimed that he was hearing voices and expressed thoughts of self-harm. A suicide alert was issued. The decedent was already taking prescribed medications. [On February 5, 2002,] Wilcox, the jail physician, continued the decedent's psychotropic medications of 1 mg Risperdal[1] three times daily and 40 mg Celexa[2] daily, the doses prescribed in December 2001.
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> On or around February 10, 2002, the decedent was hearing voices and wanted to hurt someone in his cell. Conlon (a consulting psychiatrist) and Wilcox visited the decedent on February 12, 2002. Conlon [believing that Morden was suffering from paranoid schizophrenia and polysubstance abuse,] recommended that Wilcox increase the decedent's Risperdal dose [and that he be rechecked in a month]. Conlon asserts that Wilcox was free to implement or reject that recommendation. The decedent's Risperdal dose was increased [by Wilcox] according to Conlon's recommendation.
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> On February 27, 2002, a sheriff's deputy found the decedent unresponsive in his cell. He was rocking back and forth in a fetal position. His speech was slow. On March 5, 2002, the decedent was again put on suicide watch after reporting that voices were telling him to stab himself with his pencil. When Conlon visited the decedent on March 12, 2002, although she noted some improvement, she recommended an increase of Risperdal. [Wilcox increased Morden's medication accordingly.]
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> Plaintiff visited the decedent on March 15, 2002, and found him acting "druggy." Plaintiff told a social worker at the jail that she was worried about her son. On March 18, 2002, the social worker reported that the decedent got dizzy and that his vision blacked out when he stood up. Wilcox [saw Morden on March 19, 2002 and] noted that . . . [he] suffered from head rushes, and that the side effects had started the last time his Risperdal dosage was increased. Wilcox took

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[1] This Court's prior opinion resolved the propriety of summary disposition of plaintiff's federal claims against defendant Marilyn Conlon, M.D., the psychiatrist treating Morden at the time of his death.

the decedent's blood pressure[3] [and noted that Morden was in no acute distress and that his vital signs were normal]. Wilcox recommended a psychiatric consultation [regarding a possible change in medication, and ordered blood work, which was unremarkable].

On March 23, 2002, Conlon visited the decedent and noted the decedent's complaints of tingling, head rush when he stood up, and being unable to stand without holding onto a wall. Conlon stated that improvement [in Morden's psychiatric symptoms] with Risperdal was apparent, but that the drug was likely causing orthostatic hypotension,[4] so she suggested switching to a different neuroleptic, according to the following schedule:

- Seroquel (another antipsychotic medication) 100 mg at bedtime for two days, then 200 mg at bedtime for two days, then 300 mg for four days, then 400 mg at bedtime;

- Decrease Risperdal by 2 mg with each increase of Seroquel; and

- Continue Celexa dosage unchanged.

[Wilcox implemented Conlon's recommendation.] On March 26, 2002, Wilcox [saw Morden again and] noted that [he] had lost more weight, spoke in a low voice with few words, walked stiffly without head or arm movement, and was "statue-like." [Wilcox also noted that he felt that Morden might be "overmedicated," but because Morden's medication was being changed according to Conlon's suggested schedule, Wilcox did not change Morden's medication or request another consult from Conlon, instead recommending a recheck in two weeks. Wilcox then saw Morden two days later, on March 28, 2002 for an unrelated complaint regarding a possible sexually transmitted disease. Wilcox did not note any unusual behavior or symptoms at that time.]

On April 1, 2002, [while sitting at a table with other inmates, playing cards,] the decedent began clenching his fists and exhibiting seizure-like activity. He was held up by another inmate in order to prevent him from falling to the floor. The decedent was eventually lowered to the floor while the other inmates called for assistance. Cardiopulmonary resuscitation was initiated at the scene. The decedent was defibrillated within 90 seconds of the witnessed cardiac arrest but did not respond. Paramedics took the decedent to a hospital emergency department, where he arrived without any heart activity and was pronounced dead.

An autopsy found no determinable cause of death. Dr. Bader Cassin, Washtenaw County Chief Medical Examiner, testified that in his opinion the decedent "probably" died of a cardiac arrhythmia caused by medications. Dr. Cassin testified that he did not believe that the decedent had neuroleptic malignant syndrome (NMS) when he died. Plaintiff's expert, Dr. Joel Silberberg, opined that the decedent suffered from NMS when he died. Dr. Silberberg stated that the

basis for his opinion was that the decedent was suffering from symptoms of EPS (extrapyramidal syndrome) and autonomic instability.

According to the testimony in the record, EPS consists of symptoms resembling Parkinson's tremors that are side effects of psychotropic medications. NMS, on the other hand, is a fatal disease and a medical emergency. It is a rare reactive condition to psychotropic medications that can occur after just the first dose, or after several months of treatment. NMS occurs mostly in males, and involves lead-pipe rigidity, high fever, dehydration, sweating, *elevated* blood pressure, fast heart rate and respiration, agitation, elevated white blood cell count, difficulty swallowing, and autonomic instability. According to plaintiff, muscle wasting and elevated myoglobin are also signs. The decedent had a myoglobin level of 562, which plaintiff asserts is very high. Wilcox testified that the decedent was exhibiting lead-pipe rigidity.

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[1] Risperdal is an antipsychotic medication. It is categorized as an "atypical" antipsychotic (like Clozaril, Zyprexa or Seroquel). Its method of action is that of a serotonin and dopamine receptor antagonist (SDA). *Tarascon Pocket Pharmacopoeia 2000,* p. 70.

[2] Celexa is an antidepressant medication. It is a selective serotonin reuptake inhibitor (SSRI). The maximum recommended daily dose is 40 mg. *Tarascon Pocket Pharmacopoeia 2000,* p. 68.

[3] Plaintiff posits that Wilcox apparently thought he was ruling out postural or orthostatic hypotension (a condition in which the blood pressure abnormally decreases when moving from a sitting to a standing position), which plaintiff asserts is a sign of neuromalignant syndrome (NMS).

[4] Orthostatic hypotension, or postural hypotension, occurs when a patient stands after sitting or lying down. Falling blood pressure may cause the patient to faint. *The Signet Mosby Medical Encyclopedia* (Revised Edition, 1996), p. 407.

[*Morden v Grand Traverse County*, 275 Mich App 325, 327-331; 738 NW2d 278 (2007) (emphasis in original).]

Leslie Morden, decedent's father, was appointed personal representative of Morden's estate on June 12, 2002. Nearly two years later, on June 11, 2004, he mailed a notice of intent to defendants; he did not file suit. On July 9, 2004, plaintiff (decedent's mother) was named successor personal representative of the estate; her letters of authority were issued that same day. On December 13, 2004, plaintiff filed the instant complaint, alleging that defendants violated Morden's Fourteenth Amendment rights in violation of 42 USC 1983, by acting with deliberate indifference in denying him appropriate medical treatment, that the county defendants pursued policies showing a deliberate indifference to constitutional violations, and that the professional defendants committed malpractice and were grossly negligent in their medical treatment of Morden.

Defendants filed several motions for summary disposition on a variety of grounds. On February 3, 2006, the trial court granted Conlon's and Well-Spring Psychiatry, PC's[2] motion for summary disposition on plaintiff's medical malpractice claims based on statute of limitations grounds. On February 7, 2006, the trial court granted Wilcox's motion for summary disposition on the state law medical malpractice claims on the same grounds. On March 31, 2006, the trial court granted defendant Schofield's motion for summary disposition on statute of limitations grounds, while at the same time denying plaintiff's motion for reconsideration of the orders granting summary disposition to Conlon and Wilcox. Next, on April 12, 2006, the trial court granted summary disposition of plaintiff's federal claims to defendant Schofield.[3] Then, on April 14, 2006, the trial court granted defendant Wilcox summary disposition as to the remaining constitutional and § 1983 claims against him. On May 7, 2007, following issuance of this Court's published opinion addressing the propriety of summary disposition of the federal claims against Conlon, *Morden*, *supra*, the trial court entered a final order disposing of the remaining claims set forth in plaintiff's complaint.

Plaintiff filed a delayed application for leave to appeal on April 25, 2008, which this Court granted on October 1, 2008. In the instant appeal, plaintiff takes issue with the trial court's decision summarily disposing of the estate's state law medical malpractice claims against each of the professional defendants on statute of limitations grounds, pursuant to MCR 2.116(C)(7), and with the trial court's decision summarily disposing of the estate's federal claims against defendants Wilcox and Schofield, pursuant to MCR 2.116(C)(8) and (10), on the basis that neither of those defendants acted with a sufficiently culpable mental state to support the claims asserted against them. Plaintiff does not claim error regarding the dismissal of claims against any of the other defendants originally named in the complaint.

Plaintiff first argues that the trial court erred by dismissing her medical malpractice claim against the medical professional defendants as untimely filed. We agree.

This Court reviews de novo a trial court's decision on a motion for summary disposition pursuant to MCR 2.116(C)(7), accepting plaintiff's well-pleaded allegations as true and construing them in plaintiff's favor, to determine whether the complaint was timely filed. *Estate of Dale*, 279 Mich App 676, 683; 760 NW2d 557 (2008). This Court also reviews de novo questions of statutory interpretation and the application of statutes of limitation. *Id*.

A medical malpractice plaintiff has two years from the date a cause of action accrues in which to file suit. MCL 600.5805(6). A medical malpractice claim generally "accrues at the time of the act or omission that is the basis for the claim of medical malpractice." MCL 600.5838a(1). Thus, plaintiff's cause of action for medical malpractice accrued on the date of Morden's death – April 1, 2002. Absent any applicable savings provision, then, the two-year

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[2] Plaintiff asserted that Well-Spring Psychiatry was vicariously liable for Conlon's conduct in treating Morden.

[3] The trial court also granted summary disposition to the county defendants on various procedural and substantive grounds not at issue here.

limitations period expired on April 1, 2004. However, the wrongful death saving statute, MCL 600.5852, provides personal representatives with additional time to file suit on behalf of a decedent's estate. *Estate of Dale, supra*. MCL 600.5852 provides:

> If a person dies before the period of limitations has run or within 30 days after the period of limitations has run, an action which survives by law may be commenced by the personal representative of the deceased person at any time within 2 years after letters of authority are issued although the period of limitations has run. But an action shall not be brought under this provision unless the personal representative commences it within 3 years after the period of limitations has run.

In *Eggleston v Bio-Med Applications of Detroit, Inc*, 468 Mich 29, 30; 658 NW2d 139 (2003), our Supreme Court addressed "whether a successor personal representative has two years after appointment to file an action on behalf of an estate under the wrongful death saving statute, MCL 600.5852, or whether the two-year period is measured from the appointment of the initial personal representative." Finding the former to be the case, the Court reasoned that:

> The statute [MCL 600.5852] simply provides that an action may be commenced by the personal representative "at any time within 2 years after letters of authority are issued although the period of limitations has run." The language adopted by the Legislature clearly allows an action to be brought within two years after letters of authority are issued to the personal representative. The statute does not provide that the two-year period is measured from the date letters of authority are issued to the initial personal representative. [*Eggleston, supra*, at 33 (citations omitted).]

Thereafter on a different but somewhat related issue, this Court rejected the plaintiffs' assertion that the trial court should have permitted a voluntary dismissal without prejudice, rather than to have summarily disposed of an untimely complaint on limitations grounds, so that a new personal representative could be appointed to file suit on behalf of the estate. *McLean v McElhaney*, 269 Mich App 196; 711 NW2d 775 (2005). This Court distinguished *Eggleston, supra*, on the basis that the *McLean* plaintiffs had the full two years permitted by the savings statute in which to file their complaint, unlike the initial personal representative in *Eggleston*, but simply were negligent in calculating the proper time in which to file that complaint. Of note, however, our Supreme Court subsequently reversed this Court's decision in *McLean*, remanding for entry of an order denying the defendant's motion for summary disposition, on the basis of its order in *Mullins v St Joseph's Mercy Hosp*, 480 Mich 948; 741 NW2d 300 (2007). *McLean v McElhaney*, 480 Mich 978; 741 NW2d 840 (2007).

In *Braverman v Garden City Hosp*, 275 Mich App 705; 740 NW2d 744 (2007) (*Braverman II*), a special panel of this Court, convened to address a conflict on another issue,[4]

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[4] The special panel was convened to address a conflict between *Braverman v Garden City Hosp*, 272 Mich App 72; 724 NW2d 285 (2006) (*Braverman I*) and *Verbrugghe v Select Specialty* (continued…)

reiterated that a successor personal representative has a new two-year period in which to file a medical malpractice case from the time he or she is granted letters of authority, so long as he or she acts within three years after the period of limitations has run.[5] Our Supreme Court summarily affirmed. *Braverman v Garden City Hosp*, 480 Mich 1159; 746 NW2d 612 (2008).

Most recently, this Court squarely addressed the issue presented here, that is, whether a successor personal representative is entitled to his or her own two-year saving period after the first personal representative served a full two-year term but failed to file a claim within that time. *Estate of Dale*, *supra* at 686. This Court determined, consistent with *Eggleston*, that successor personal representatives are entitled to their own two-year savings period following issuance of their letters of authority, regardless whether the prior personal representative served a full two-year term, so long as the complaint is filed within three years after the limitations period has run, as required by MCL 600.5852.[6] *Id*.

More specifically, *Estate of Dale* presented this Court with the following facts. C. Joyce Dale died on December 15, 2000. Letters of authority were issued to the original personal representative of Dale's estate on February 23, 2001. The initial personal representative served the defendants with a notice of intent to file a medical malpractice claim on February 19, 2003. On August 15, 2003, after the original personal representative had served for more than two years, a successor personal representative was appointed. Seven days later, on August 22, 2003, the successor personal representative filed a complaint alleging medical malpractice against the defendants. The defendants moved for summary disposition. The trial court denied their motions, concluding that the claim was timely filed under MCL 600.5852 and, further, that the successor representative was entitled to rely on the notice of intent served by her predecessor. *Estate of Dale*, *supra* at 677-679. This Court affirmed the trial court's ruling, explaining that

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Hosp-Macomb Co, Inc, 270 Mich App 383; 715 NW2d 72 (2006), regarding whether "the same natural person who files the notice of intent must file the complaint in situations involving a duly appointed personal representative who succeeds a duly appointed predecessor personal representative." This Court determined that a successor personal representative could rely on the notice of intent filed by a predecessor, thus vacating part III of *Braverman I*. *Braverman II*, *supra* at 707, 714-716.

[5] In *Braverman I*, *supra* at 75-76, this Court affirmed the trial court's determination under *Eggleston* that the plaintiff successor representative's complaint was not time-barred where she filed her complaint within two years of issuance of her letters of authority, regardless that the complaint was filed more than two years after issuance of letters of authority to the initial representative. *Braverman II* left that portion of *Braverman I* intact, reiterating that "a successor personal representative has a new two-year period in which to file a medical malpractice case from the time he or she is granted letters of authority, if he or she acts within three years after the period of limitations has run. *Eggleston*, 468 Mich at 33." *Braverman II*, *supra* at 711.

[6] We note that, prior to *Estate of Dale*, in *Washington v Sinai Hosp of Greater Detroit*, 478 Mich 412, 417; 733 NW2d 755 (2007), our Supreme Court declined to address this question, despite asking the parties to brief it, finding its resolution to be unnecessary to disposition of the appeal. Thus, *Estate of Dale* is the first, and only, published decision addressing this issue.

> MCL 600.5852 does not provide that the two-year saving period is measured from the date that letters of authority are issued to the initial personal representative; instead, the statute provides that the two-year period is measured from the date that letters of authority are issued to *any* personal representative, regardless of whether that person is the initial personal representative or a successor personal representative. [*Estate of Dale, supra* at 686.]

This Court thus concluded that because the plaintiff filed her medical malpractice claim within seven days of issuance of her letters of authority, and within three years of the expiration of the limitations period as required by MCL 600.5852, that claim was timely regardless that the initial personal representative served for more than two-years before the successor was appointed. *Id.* at 678, 686.[7]

Here, decedent's cause of action for medical malpractice accrued on April 1, 2002. Thus, the limitations period for filing that action ran on April 1, 2004, and that last day on which MCL 600.5852 would permit the action to be filed was April 1, 2007. Plaintiff's letters of authority were issued on July 9, 2004, and she filed the instant medical malpractice claim on December 13, 2004. Therefore, here, as in *Eggleston* and *Estate of Dale*, plaintiff was "the personal representative" of the estate, and she filed her claim within two years after letters of authority were issued, and within three years after the period of limitations had run, as permitted by MCL 600.5852. Thus, plaintiff's medical malpractice action was timely filed and the trial court erred by concluding otherwise.[8] *Eggleston*, *supra*; *Estate of Dale, supra*.

Plaintiff next asks this Court to declare that governmental immunity is not available to defendants Wilcox and Schofield, because MCL 691.1407 provides that there is no immunity with respect to the provision of medical treatment except that provided in a hospital owned or operated by the Department of Community Health or by the Department of Corrections, and the Grand Traverse County Jail is not operated by either Department.[9] However, this issue was not

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[7] Defendant Wilcox argues that *Estate of Dale* was wrongly decided and that it conflicts with *McLean, supra* at 196, which Wilcox asserts remains binding on this Court despite its reversal. However, this Court has previously declared that "*McLean* [] is not binding on us because that decision has been reversed by our Supreme Court on an independent, dispositive ground." *Estate of Dale*, supra at 686-687, n 5. Further, in *McLean*, the initial personal representative actually filed an untimely complaint; *McLean did* not squarely address the question at issue here, where no such untimely complaint was filed. That question was first addressed by this Court in *Estate of Dale*. Thus, this Court is obligated to follow *Estate of Dale*, which is dispositive on this issue, and not this Court's earlier reversed decision in *McLean*, which did not address it.

[8] Because we find that plaintiff's state law medical malpractice claim was timely filed, we need not address her assertion that, even were that not the case, judicial tolling of the limitations period would be warranted under the circumstances present here.

[9] MCL 691.1407(4) provides in relevant part:

> This act does not grant immunity to a governmental agency or an employee or agent of a governmental agency with respect to providing medical care or treatment to a patient, except medical care or treatment provided to a patient in a

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raised by any party in, or addressed in any manner by, the trial court and defendants do not assert that governmental immunity provides any alternative basis for affirmance of the summary disposition of the state law claims against them. Therefore, we decline to address it at this time, leaving it for further development in the trial court on remand, should the parties deem it appropriate to raise this issue in that forum.

Finally, plaintiff asserts that the trial court erred by dismissing her federal claims against Wilcox and Schofield pursuant to MCR 2.116(C)(8) and (10). We disagree.

This Court reviews a trial court's decision on a motion for summary disposition de novo. *Dressel v Ameribank*, 468 Mich 557, 561; 664 NW2d 151 (2003); *Maiden v Rozwood*, 461 Mich 109, 119-120; 597 NW2d 817 (1999); *Simko v Blake*, 448 Mich 648, 654; 532 NW2d 842 (1995). A motion for summary disposition under MCR 2.116(C)(8) tests the legal sufficiency of a claim based on the pleadings alone, accepting all well-pleaded factual allegations as true and construing them in a light most favorable to the nonmoving party, to determine whether the plaintiff has stated a claim upon which relief can be granted. Only if no factual development could justify the plaintiff's claim for relief can the motion be granted. *Morden, supra* at 331.

When considering a motion for summary disposition under MCR 2.116(C)(10), a court considers the affidavits, pleadings, depositions, admissions, and documentary evidence submitted, to the extent that they are admissible in evidence, together with all reasonable inferences therefrom, in the light most favorable to the non-moving party, to determine whether a genuine issue of any material fact exists for resolution by the fact-finder. *Morden, supra*. Summary disposition is appropriate where the proffered evidence fails to establish a genuine issue regarding any material fact, and the moving party is entitled to judgment as a matter of law. *Id.*

As this Court previously explained in *Morden, supra* at 332-334:

> Any person who, under color of state law, deprives another of rights protected by the constitution or laws of the United States, is liable under 42 USC 1983. *Monell v Dep't of Social Services of the City of New York*, 436 US 658, 690-691; 98 S Ct 2018; 56 L Ed 2d 611 (1978). "[T]o survive summary [disposition] in a 1983 action, [plaintiff] must demonstrate a genuine issue of material fact as to the following 'two elements: 1) the deprivation of a right secured by the Constitution or laws of the United States and 2) the deprivation was caused by a person acting under color of state law.'" *Johnson v Karnes*, 398 F3d 868, 873 (CA6, 2005) (citation omitted).
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> The Eighth Amendment of the United States Constitution provides: "Excessive bail shall not be required . . . nor cruel and unusual punishments inflicted." "Cruel and unusual punishment prohibited by the Eighth Amendment

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> hospital owned or operated by the department of community health or a hospital owned or operated by the department of corrections . . .

may include the denial of medical or psychological treatment." *Mosqueda v Macomb Co Youth Home*, 132 Mich App 462, 471; 349 NW2d 185 (1984). "Medical treatment that is so grossly incompetent, inadequate, or excessive as to shock the conscience or to be intolerable to fundamental fairness violates the eighth amendment." *Rogers v Evans*, 792 F2d 1052, 1058 (CA 11, 1986).

The Eighth Amendment does not apply to pretrial detainees, such as the decedent. However, detainees are entitled under the Fourteenth *Amendment's* substantive Due Process Clause to the same care as prison inmates. *Graham v Washtenaw Co*, 358 F3d 377, 383 (CA 6, 2004) (the Fourteenth Amendment "affords pretrial detainees a due process right to adequate medical treatment that is analogous to the Eighth Amendment rights of prisoners"). The same standard, deliberate indifference, applies to both detainees and convicts. See *id.*; *Watkins v Battle Creek*, 273 F3d 682, 686 (CA 6, 2001). A "failure or refusal to provide medical care, or treatment so cursory as to amount to no treatment at all, may, in the case of serious medical problems, violate the Fourteenth Amendment." *Tolbert v Eyman*, 434 F2d 625, 626 (CA 9, 1970).

In *Estelle v Gamble*, 429 US 97, 98-101, 97 S Ct 285, 50 L Ed 2d 251 (1976), the United States Supreme Court, in determining whether a cause of action existed under § 1983, analyzed Eighth Amendment prohibitions against cruel and unusual punishments. *Id.* at 102-103. The Court concluded that "deliberate indifference to serious medical needs of prisoners constitutes the unnecessary and wanton infliction of pain, proscribed by the Eighth Amendment." *Id.* at 104, (internal quotation marks and citation omitted). The Court recognized, however, that a violation does not occur every time a prisoner receives inadequate medical treatment. *Id.* It held that "an inadvertent failure to provide adequate medical care" is not actionable and that a "*complaint that a physician has been negligent in diagnosing or treating a medical condition does not state a valid claim of medical mistreatment under the Eighth Amendment.*" *Id.* at 105-106 (emphasis added). Rather, "a prisoner must allege acts or omissions sufficiently harmful to evidence deliberate indifference to serious medical needs." *Id.* at 106.

It is a high standard. "Deliberate indifference" is the reckless disregard of a substantial risk of serious harm; *mere negligence, or even gross negligence, will not suffice*. *Farmer v Brennan*, 511 US 825, 835-836; 114 S Ct 1970; 128 L Ed 2d 811 (1994); *Williams v Mehra*, 186 F3d 685, 691 (CA6, 1999) (en banc) [emphasis added].

A claim of cruel and unusual punishment has both objective and subjective components. The objective component requires a showing that the plaintiff's medical needs were sufficiently serious. *Hunt v Reynolds*, 974 F2d 734, 735 (CA6, 1992). The subjective component requires a showing that the defendants were deliberately indifferent to the plaintiff's serious medical needs. See *id.* In other words, the deliberate indifference standard contains both an objective component (Was the deprivation sufficiently serious?) and a subjective component (Did the officials act with a sufficiently culpable state of mind?). *Wilson v Seiter*, 501 US 294, 298; 111 S Ct 2321; 115 L Ed 2d 271 (1991).

Clearly, then, the standard for establishing a claim of deliberate indifference

> is more than simple negligence, and it approaches, but does not reach, an intent to punish. "*[W]hen a prison doctor provides treatment, albeit carelessly or inefficaciously, to a prisoner, he has not displayed a deliberate indifference to the prisoner's needs, but merely a degree of incompetence which does not rise to the level of a constitutional violation.*" *Karnes, supra* at 875 (internal quotation marks and citation omitted; emphasis added). "However, it is not necessary for a plaintiff to show that the official acted for the very purpose of causing harm or with knowledge that harm will result." *Id.* (internal quotation marks and citation omitted). "[D]eliberate indifference to a substantial risk of serious harm to a prisoner is the equivalent of recklessly disregarding that risk." *Id.* (internal quotation marks and citations omitted). [*Id*. at 338-339 (emphasis in original).]

Applying this standard to the instant action, there is no genuine issue of material effect with regard to plaintiff's deliberate indifference claim against defendant Wilcox. Plaintiff's allegations against Wilcox, which speak of him "failing and neglecting" to take certain actions and of acting "negligently and inappropriately" in other regards, sound in negligence, or perhaps gross negligence. Likewise, plaintiff relies on expert testimony that suggests that Wilcox failed to comply with the standard of care required of a family practice doctor or primary care physician in his treatment of Morden, by failing to adequately monitor his vital signs, to affirmatively inquire of Morden, or to chart such inquiry if made, regarding continuation of extrapyramidal symptoms, and to perform additional physical examination and testing regarding the cause of Morden's symptoms. Of course, allegations and evidence regarding whether Wilcox complied with the standard of care required of him

> unmistakably suggest a malpractice theory, but [plaintiff presents and] we find no authority that a § 1983 claim may be brought solely on the basis that a professional has committed malpractice. Moreover, evidence that [Wilcox] may have failed to comply with the requisite standard of care is insufficient to prove cruel and unusual punishment because the constitutional claim cannot be based on negligence. [*Morden, supra* at 334 (citations omitted).]

Further, as to Wilcox's mental culpability, plaintiff presents no evidence to indicate that Wilcox knew of, but disregarded, an excessive risk to Morden's health or safety. Plaintiff's family practice standard of care expert, testified that "[i]f Dr. Wilcox truly entertained the potential diagnosis of NMS, and ignored it willfully, then it was reckless" but he did not conclude that such was the case. Indeed, plaintiff's expert was unwilling to testify that Wilcox acted in a manner that was grossly negligent, reckless or deliberately indifferent to Morden's serious medical needs. And, there is no evidence that Wilcox ever drew any inference that the decedent suffered from NMS, but ignored that inference. Indeed, Wilcox repeatedly denied ever suspecting that Morden had NMS, or that any such inference was warranted by Morden's symptoms and behavior. Instead, Wilcox testified that Morden was having minor side effects from his psychiatric medications, that his medications were changed, and that he was "doing better with the changes in the medication[s]." Wilcox described Morden's symptoms as typical for the medications he was taking and repeatedly disavowed that Morden was seriously ill. Wilcox also testified that had he suspected that Morden was suffering from NMS, he would have

done a whole metabolic profile and would have "ship[ped him] out the door so darn fast, as soon as EMS could get here."

Considering Wilcox's deposition testimony, and the unwillingness of plaintiff's expert to characterize Wilcox's treatment of Morden as intentionally or recklessly disregarding Morden's interests, plaintiff has not presented sufficient evidence to raise a genuine issue of material fact that Wilcox acted with a sufficiently culpable state of mind to support plaintiff's federal claims against him. Thus, the trial court properly granted summary disposition of these claims.

Further here, as we explained in our prior opinion in this case, plaintiff's theory of causation is insufficient to establish the requisite proximate cause required by § 1983. *Morden*, *supra* at 335-336. Plaintiff continues to assert that Morden died from NMS, and alleges that Wilcox caused or contributed to the development of NMS, and failed to timely diagnose it, causing Morden's death. However, Wilcox and Conlon each testified that they did not believe that Morden had NMS. Additionally, both the medical examiner and plaintiff's pathologist, Bader Cassin, opined that Morden died from cardiac arrhythmia and not from NMS.[10] And, while plaintiff's psychiatric expert, Joel Silberberg, concluded that NMS caused plaintiff's death, this Court previously observed that "this testimony amounts to speculation and conjecture, because it does not exclude other possibilities to a reasonable degree of certainty," and that therefore, "the evidence is insufficient to raise a genuine issue of fact" as to causation. *Morden*, *supra* at 335.

As regards the treatment afforded to Morden by defendant nurse Schofield, plaintiff's complaint likewise speaks of her "failing and neglecting" to take certain actions and of acting "negligently and inappropriately" toward Morden's medical needs. Again, such allegations sound in negligence, or perhaps, gross negligence. Plaintiff offers no evidence or testimony to establish that Schofield acted with a sufficiently culpable mental state to support the federal claims asserted against her. And, Schofield expressly disavowed any intent to disregard any serious medical need presented by Morden. Plaintiff does not point to any particular conduct by Schofield as demonstrating sufficient mental culpability, and we find no basis in the record before us for such assertion. Thus, the trial court correctly concluded that summary disposition of plaintiff's federal claims against defendant nurse Schofield was warranted.[11]

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[10] Of note, Cassin opined that Morden died of cardiac arrhythmia "probably" or "most likely" related to or precipitated by his medication. However, Cassin specifically stated that he does not believe that Morden had NMS. Cassin also noted that Morden had an enlarged AV node artery and that "numerous, if not most, of the arterials in [Morden's] heart were thicker than normal," and he acknowledged that either of these conditions could have made Morden more prone to a sudden cardiac death. Cassin also agreed that he could not rule out that Morden suffered a sudden cardiac arrhythmia unrelated to his medications.

[11] Because we conclude that plaintiff failed to establish any genuine issue of material fact concerning her federal claims against defendants Wilcox and Schofield, we need not address whether those defendants would be entitled to qualified immunity from those claims. Were we to address that issue, however, we note that we would conclude, consistent with our earlier

(continued…)

We affirm in part, reverse in part and remand for further proceedings consistent with this opinion. We do not retain jurisdiction. No taxable costs pursuant to MCR 7.219, neither party having prevailed in full.

/s/ Peter D. O'Connell
/s/ Richard A. Bandstra
/s/ Pat M. Donofrio

(…continued)

opinion in *Morden*, *supra* at 340-343, that they would be entitled to such immunity.